DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 - 0 1 0

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

Section 702 of the Medicare, Medicaid + SCHIP – BIPA

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ No Budget Impact
b. FFY 2004 $ " " "

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pp 1b, 5q

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.1-9-B, pp 1b, 5q

10. SUBJECT OF AMENDMENT:
REVISIONS TO THE PROSPECTIVE PAYMENT SYSTEM (PPS) FOR FEDERALLY QUA;IFIED HEALTH CENTERS AND RIRAL HEALTH CLINICS

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: MARK TRAIL

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED: July 30, 2003

16. RETURN TO:
Department of Community Health
Medical Assistance Plans
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 4, 2003

18. DATE APPROVED: December 30, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Hugh Webster

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

B. Clinic Services (continued)

3. Federally Qualified Health Centers (FQHC) (COMMUNITY HEALTH CENTERS SERVICES (CHCS)

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1,2001, reimbursement is provided for "core" services and other ambulatory services (excluding in- house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average FQHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY 2000. Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during FY 2001 for services that only occurred in calendar year 2000. Cost reports for the FQHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each FQHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, FQHCs will be paid their interim rate effective December 31, 2000. When the baseline rates and are established, they will be paid retroactive to January 1, 2001.

The baseline rates effective January 1, 2001 will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after October 1,2001 based on the MEI and for changes in the FQHC's scope of services during January 1, 2001 through September 30, 2001. For Federal Fiscal Year (FFY) 2002 and FFYS thereafter, per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the FQHC's scope of services during the prior FFY.

For newly qualified FQHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1,2001. Centers that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

For purposes of this plan, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the center's responsibility to recognize any changes in their scope of services and to notify the Department of these changes and to provide the Department with documentation and projections of the cost and volume impact of the change.

If an FQHC provides core services pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State shall provide payment of a supplemental payment equal to the amount (if any) by which the PPS rate calculated above exceeds the amount of the payments provided under the contract. These supplemental payments shall be made pursuant to a payment schedule of four months or less agreed to by the State and the Federally Qualified Health Center.

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Federally Qualified Health Center Services (FQHC) Community Health Center Services (CHC). Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Rural Health Clinic Services (RHC)

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for "core" services and other ambulatory services (excluding in-house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average of the RHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY2000., Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during FY2001for services that only occurred in calendar year 2000. Cost reports for the RHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each RHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, RHCs will be paid their interim rate effective December 31,2000. When the baseline rates are established, they will be paid retroactive to January 1,2001.

The baseline rates effective January 1,2001 will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after October 1, 2001 based on the MEI and for changes in the RHC's scope of services during January 1, 2001 through September 30, 2001. For Federal Fiscal Year (FFY) 2002 and FFYs thereafter, the per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the RHC's scope of services during the prior FFY.

For newly qualified RHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1,2001. Clinics that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

For purposes of this plan, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the clinic's responsibility to recognize any changes in their scope of services and to notify the Department of those changes and to provide the Department with documentation of and projections for the cost and volume of the change.

If a RHC provides core services pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State shall provide payment of a supplemental payment equal to the amount (if any) by which the PPS rate calculated above exceeds the amount of the payments provided under the contract. These supplemental payments shall be made pursuant to a payment schedule of four months or less agreed to by the State and the Rural Health Clinic.

An alternative payment methodology is established for services furnished in Rural Health Clinics located at Critical Access Hospitals. The reimbursement methodology will follow the provisions established in Attachment 4.19-B, Page 8a.1 (Outpatient Hospital). All clinics affected by this methodology have agreed and their payments will at least equal the amount they would have received under the PPS methodology. .

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Rural Health Clinic Services (RHC). Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment